

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 3 FOR YOURSELF. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5, 01905		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Samuel Spedden Abey, Sr.										20. DATE KNOWN OF DEATH MONTH DAY YEAR 1-3 1985		21. HOUR A M
3. SEX M	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 7, 1911	6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan. 3, 1985		24. HOUR A M 10A				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.						
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman-Self Employed		12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE MD	13b. COUNTY Dorchester	13c. CITY OR TOWN Secretary	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 349 Poplar St., 21664								
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Henry Abey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Seymour								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 219-07-8497		17. INFORMANT ADDRESS Rt. 1, Box 195 Samuel S. Abey, Jr. E. New Market, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>John Mace, Jr.</i>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 1/3/85				
EXAMINER'S NAME (TYPE OR PRINT) John Mace, Jr.				ADDRESS Cambridge, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-7-85		23c. NAME OF CEMETERY OR CREMATORY MD Eastern Shore Vet.				23d. LOCATION CITY OR TOWN COUNTY STATE Beulah Dorchester MD				
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD						25a. DATE REC'D. BY REGISTRAR JAN 25 1985		25b. REGISTRAR'S SIGNATURE <i>John R. Riddell</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 0 1 9 0 6			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
ARRELGA BRAXTON SR				1 19 85			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		BLACK		MONTH DAY YEAR		YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
VIRGINIA		U.S.A.				DORCHESTER MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					
CAMBRIDGE		DORCHESTER GENERAL HOSPITAL					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
TEACHER		HIGH SCHOOL					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
MD				DORCHESTER		CAMBRIDGE	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Clemmie Braxton				Daisy Moore Braxton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				228-22-9158			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) AORTIC STENOSIS							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 12, 19 85, to JANUARY 14, 19 85, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Adolfo Correa				M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		JAN 19, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Adolfo Correa				DORCHESTER GENERAL HOSPITAL, CAMBRIDGE			
23a. BURIAL, CREMATION, REMOVAL (SEE #1)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		1/26/85		Mt. Pleasant Ceme		CITY OR TOWN COUNTY STATE	
				Salisbury Md.		DORCHESTER MD.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
NAME ADDRESS				25b. REGISTRAR'S SIGNATURE			
STEWART Funeral Home Salisbury Md.				JAN 21 1985			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item B shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Willis K. Brinsfield, Sr.			2a. DATE OF DEATH MONTH DAY YEAR January 17, 1985			2b. HOUR 5:30 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 22, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hawkeye, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD			
10. CITY OR TOWN OF DEATH Williamsburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Rhodesdale		13e. STREET ADDRESS RD 1, Box 140L 21659			
14. FATHER'S NAME FIRST MIDDLE LAST George S. Brinsfield					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie R. Blake				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-36-2082		17. INFORMANT ADDRESS Rhodesdale, Md. Willis Brinsfield, Jr., RD 1, Box 140L 21659					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recent Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Michael J. Fadden</i> MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael J. Fadden, M.D.						22e. ADDRESS 302 Collins Avenue, Hurlock, Md. 21643			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 20, 1985		23c. NAME OF CEMETERY OR CREMATORY Eldorado Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Eldorado, Dorchester, Md.		
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home,			ADDRESS 216 N. Main St.			25a. DATE REC'D. BY REGISTRAR JAN 28 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

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ORIGINAL MANUSCRIPT

RECEIVED OCT 10 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified for cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Orien W Dail					2a. DATE OF DEATH MONTH DAY YEAR 01-28-85			2b. HOUR 12 23 AM	
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 09 09 04		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
2. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) electrician		12b. KIND OF BUSINESS OR INDUSTRY building	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13e. STREET ADDRESS / ZIP CODE 503 Academy St. 21613			
14. FATHER'S NAME FIRST MIDDLE LAST George W. Dail					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Abbott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Nelson Dail Item # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION 01-27-85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Abd. Aortic Aneurysm			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 01-27-85 19 85 , to 01-28 19 85 , that (I) (we) lost saw the deceased alive on 01-28-85 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Chastinel-Galam, M.D.						22c. DATE SIGNED 01-28-85		22d. ADDRESS Dorchester Gen'l Hosp., Cambr, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 1/31/85		23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS		23d. LOCATION CITY OR TOWN COUNTY STATE HURLOCK DOR. MD.		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR JAN 31 1985		25b. REGISTRAR'S SIGNATURE <i>John R. ...</i>	

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOHNNIE H. DEAN				2a. DATE OF DEATH MONTH DAY YEAR 1 16 85			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 3 96		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.	
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATERMAN		12b. KIND OF BUSINESS OR INDUSTRY shellfish	
13a. STATE MD.		13b. COUNTY DORCHESTER		13c. CITY OR TOWN CAMBRIDGE		13d. STREET ADDRESS / ZIP CODE Box 681 21622	
14. FATHER'S NAME (TYPE OR PRINT) JOHN DEAN				15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) KATIE TOLLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-16-6401		17. INFORMANT Mrs. Leona J. Dean, same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bleeding into a</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 wks</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>COPD, Accvd, Deep Venous thrombosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>12/22</u> 19 <u>84</u> to <u>1/16</u> 19 <u>85</u> , that (1) (myself) saw the deceased alive on <u>1/15</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, circle X.)							
22b. SIGNATURE <u>Hubert J. Frey</u>		22c. DEGREE MD		22d. DATE SIGNED 1/16/85		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUBERT J. FREY</u>		22g. ADDRESS <u>ROSE HILL MED. CENTER</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 1/19/85		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Airey, Cambridge, Dor., Md.	
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR JAN 18 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

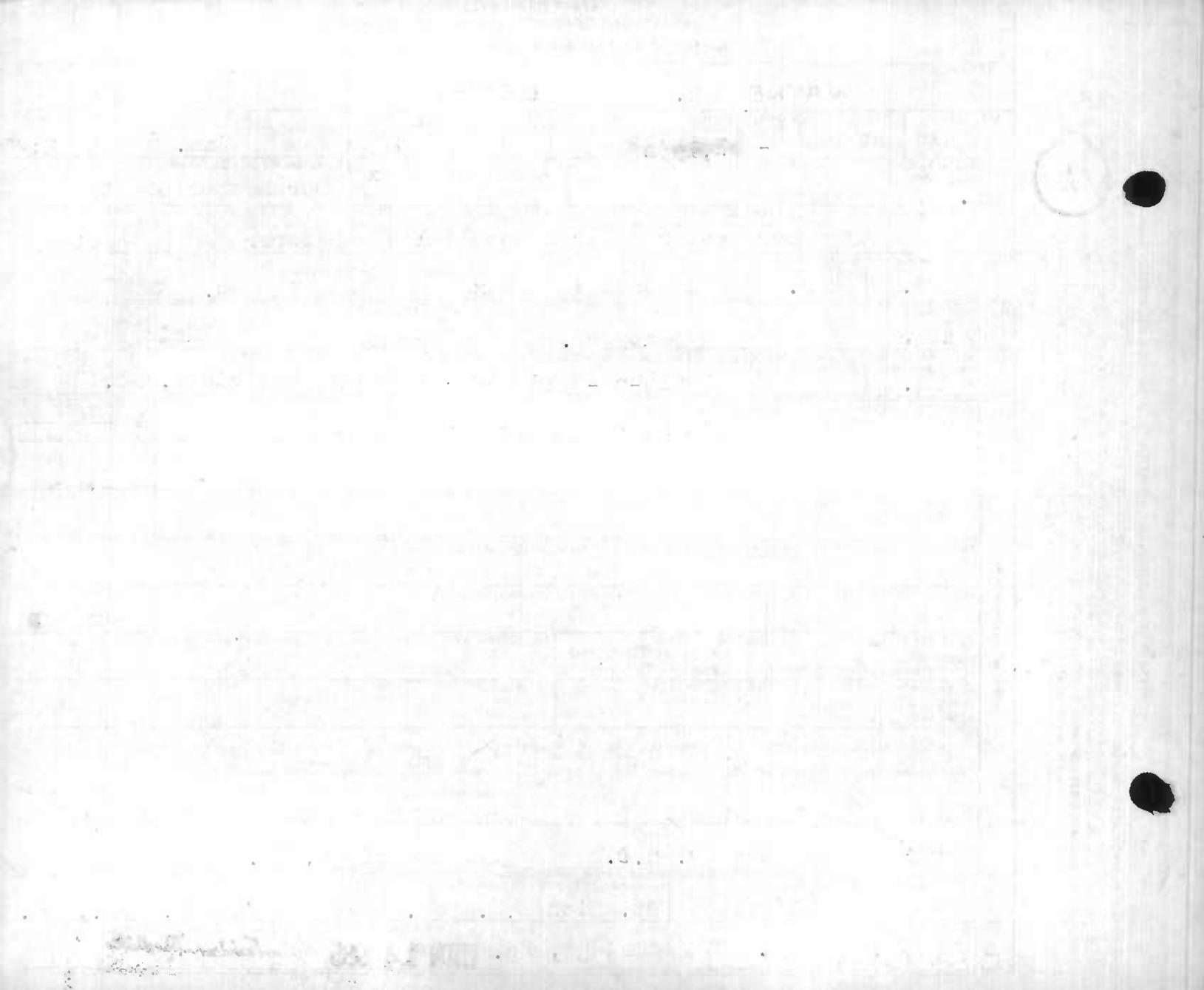
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "AT WORK" above any injury, or other traumatic event, the medicolegal investigation must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTER. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF ESTI- MATED				2b. HOUR			
WAYNE R.										DEMBOY										1-4 1985				PM			
1. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR										
Male		Negro		5-18-1958			28 YRS.						Jan. 4 1985		2:20		PM										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.											
Md.				USA								Dorchester County															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
DOA				Dorchester General Hospital								Laborer				Factory											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21613											
Md.				Dor.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				706 High St.		XXXX													
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS									
Lester				Arlene				No.		214-68-5316		Arlene Demby				Cambridge, Md.											
FIRST MIDDLE LAST				FIRST MIDDLE LAST																							
Dor.				Cambridge																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?									
																		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
						P.M. 19																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE <u>John Mace Jr.</u>										TITLE (SPECIFY) M.D. <u>DEPUTY</u> MEDICAL EXAMINER										DATE SIGNED <u>1/5/85</u>							
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.										ADDRESS Cambridge, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial						1/9/1985		Mt. Zion U.M. Cem.						East New Market, Dor. Md.													
24. FUNERAL DIRECTOR NAME <u>L.H. Boardley</u>										ADDRESS Cambridge, Md.										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
																				JAN 14 1985		<u>Julia Davidson-Randall</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Hildred A Elliott					2a. DATE OF DEATH MONTH DAY YEAR 1 28-85			2b. HOUR 8 40 P.M.		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Nov. 2, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nansemond Co., Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.				
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland					13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Will Trotter					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Dickens					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Maryland 21613 Asar C. Johnson, 859 Park Lane, Cambridge,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL ISCHEMIA DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE CORONARY ARTERIOSCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1. DIABETES MELLITUS 2. MULTIPLE STROKES 3. SICK SINUS SYNDROME										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 1-10 , 19 85 , to 1-28 , 19 85 , that (I/we) last saw the deceased alive on 1-28-85 , 19 85 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)										
22b. SIGNATURE James F. Mc Carter M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-28-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES F. MC CARTER			22e. ADDRESS 400 AURORA STREET CAMBRIDGE, MD., 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, Md.			
24. FUNERAL DIRECTOR NAME Thompson Hawkins			ADDRESS Box 45		25a. DATE REC'D. BY REGISTRAR 1-28-85					
25b. REGISTRAR'S SIGNATURE John Davidson-Rodriguez										

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELsie MATILDA GAIGLER				2a. DATE OF DEATH MONTH DAY YEAR 1 10 85			
3. SEX F		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 12 12 90		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.	
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GEN HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE MD		13b. COUNTY DORCH		13c. CITY OR TOWN CAMBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY STAGGE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE HENTHORN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-6001		17. INFORMANT ADDRESS CAMBRIDGE, MD. CATHERINE G. EDGAR RT. 4 BOX 403 21613			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED ASVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>OBS, HYPERGLYCEMIA, DEHYDRATION</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> , 19 <u>85</u> , to <u>1/10</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>1/10</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, do not view the body after death.)							
22b. SIGNATURE <u>Hubert L. Perry</u>				22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>1/12/85</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUBERT L. PERRY</u>				22f. ADDRESS <u>503 1342N ST</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE 01-12-85		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PK. MAUS.		23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR JAN 14 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

8 5 0 1 9 1 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BLANCHE DEAN HALL			2a. DATE OF DEATH MONTH 1 DAY 3 YEAR 85			2b. HOUR 9:45 M	
3. SEX F		4. RACE CAUC		5. DATE OF BIRTH MONTH 11 DAY 1 YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.	
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN FISHING CREEK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE rural 21634							
14. FATHER'S NAME FIRST JOHN MIDDLE LAST DEAN				15. MOTHER'S MAIDEN NAME FIRST MINNIE MIDDLE LAST PHILLIPS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-80-8629		17. INFORMANT son ADDRESS 21634 ROBERT HALL, Fishing Creek, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) marked cerebral hypoxic damage APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S/P CARDIAC ARREST, CEREBRAL ISCHEMIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/28 19 84 , to 1/3 19 85 , that (1) (we) last saw the deceased alive on 1/3 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (you) (did) not view the body after death.							
22b. SIGNATURE Hubert L. Flynn		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT L. FLYNN		22e. ADDRESS 503 BYRON ST.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Jan. 6, '85		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Pk.		23d. LOCATION CITY OR TOWN Airey, Cambridge COUNTY Dor. STATE Md.	
24. FUNERAL DIRECTOR NAME Curran Funeral Home		24b. ADDRESS 308 High St., Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR JAN 9 1985		25b. REGISTRAR'S SIGNATURE John Darden	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 9 1 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Julian - Handley			2a. DATE OF DEATH MONTH DAY YEAR 1/9/85		2b. HOUR 258 AM
3. SEX Male	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10-19-23	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dorchester	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 97 21613	
14. FATHER'S NAME FIRST MIDDLE LAST Fredrick Handley	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Meekin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 220-32-0652		17. INFORMANT ADDRESS Wm. W. Handley Rt. 1 Box 91 Cambridge Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Thour					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Interstitial Pulmonary Fibrosis + Resting Hypoxemia					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (PRINT) H. Noel Reynolds		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/9/85
22d. ADDRESS 408 Bynn St. Cambridge Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 1/11/85	23c. NAME OF CEMETERY OR CREMATORY Dor. Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR JAN 17 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson Reynolds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8501915			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Alice M. Jackson		2a. DATE OF DEATH MONTH DAY YEAR January 1, 1985		2b. HOUR M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR August 4, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Federalsburg, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Hurlock		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 194A		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Deshields		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 220-12-2124		17. INFORMANT ADDRESS Hurlock, Md. Frances Tilghman, Rt. 1, Box 414,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 27</u> 19 <u>83</u> , to <u>Nov 6</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>Nov 6</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William Lovett</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/8/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Lovett, M.D.		22e. ADDRESS Kerr Avenue, Denton, Maryland 21629					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Johns Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Preston, Caroline, Maryland	
24. FUNERAL DIRECTOR NAME Framptom-Hawkins		ADDRESS Federalsburg		25a. DATE REC'D. BY REGISTRAR JAN 6 1985			
25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>							

Hampton-Lawson Funeral Home, 216 N. Main St.
Federal Springs, La.

Burial Jan. 2, 1982

William J. Lovett, M.D.
Berry Avenue, Benton, Maryland 21612

220-12-2124 Frances Tilghman, Rt. 1, Box 411,
Hurlock, Md.

John Deshields
Annie

Maryland Dorchester Hurlock

Rt. 1, Box 194A X

Rt. 1, Box 194A

Housewife

Own Home

Federal Springs, Md. U.S.A.

X

Dorchester

August 4, 1920

44

Alice K. Jackson

January 1, 1982

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William M Johnson			2a. DATE OF DEATH MONTH DAY YEAR 1-16-85			2b. HOUR 8:40 A.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 09 20 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	
12b. KIND OF BUSINESS OR INDUSTRY grocery		13a. STREET ADDRESS / ZIP CODE Academy St. 21664					
13b. STATE Md.		13c. CITY OR TOWN Dor.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Academy St. 21664	
14. FATHER'S NAME FIRST MIDDLE LAST Goldsborough Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Robinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-22-9471		17. INFORMANT ADDRESS Louise M. Johnson Item #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic Obstructive Pulmonary Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 minutes

PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Coronary Artery Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> , 19 <u>85</u> , to <u>Jan 16</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>1/15</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
27b. SIGNATURE <u>E. MacLaughlin</u>				DEGREE <u>MD</u>		27c. DATE SIGNED <u>1/16/85</u>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edmund J. MacLaughlin</u>				27e. ADDRESS <u>10 Aurora St. Cambridge, Md 21613</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 1/18/85		23c. NAME OF CEMETERY OR CREMATORY Our Lady Good Counsel Churchyard		23d. LOCATION CITY OR TOWN COUNTY STATE Secretary Md	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME				25a. DATE OF REGISTRATION JAN 24 1985			
ADDRESS CAMBRIDGE MD.				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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THREE
DOMINO

Carney, Harry B.

Edward T. Hagglin

JAN 8 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO.														
1. DECEASED NAME (TYPE OR PRINT) Bradford Keene					2a. DATE OF DEATH MONTH DAY YEAR 1-7-85					2b. HOUR 7:40 AM				
3. SEX Male			4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 10 1909			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen Hosp. Tal					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) above			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Ind					13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE P.O. Box 134 21677		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Keene					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Lee									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. 213-16-7549					17. INFORMANT ADDRESS Nettie Keene Harrisville Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Neg Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) CHE DUE TO, OR AS A CONSEQUENCE OF (c) COPD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1/6 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE [Signature]					DEGREE					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 1/12/85		23c. NAME OF CEMETERY OR CREMATORY Malone Ceme			23d. LOCATION CITY OR TOWN COUNTY STATE Madison Dorchester Md.				
24. FUNERAL DIRECTOR NAME Stewart Funeral Home					25a. DATE REC'D. BY REGISTRAR JAN 9 1985					25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP



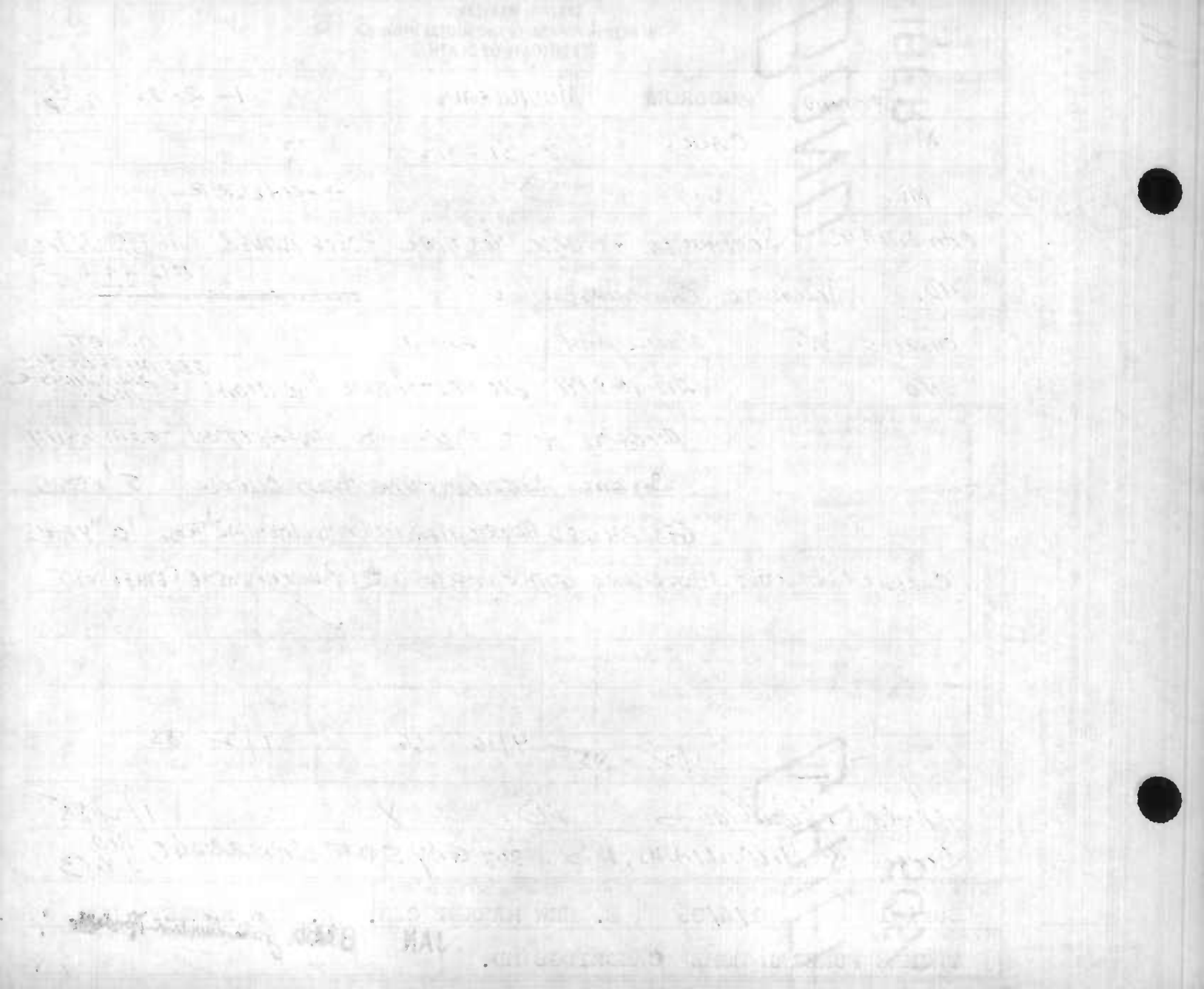
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) RAYMOND WOODROW McWILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 1-2-85		2b. HOUR 12⁰⁰ PM	
3 SEX M	4 RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 8-31-12	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH SORCHESTER MD.			
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SORCHESTER GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY IN COMMERCE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.	13b. COUNTY SORCHESTER	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1012 RACE ST 21101		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES W. McWILLIAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMIT AIRNETT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-10-8741		17. INFORMANT ADDRESS BLUTHE-RUSSELL McWILLIAMS 206 METEOR AVE CAMBRIDGE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROLONGED ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5+ YEARS 10+ YEARS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CHRONIC OBSTRUCTIVE LUNG DISEASE WITH EMPHYSEMA AND BRONCHOSPASTIC COMPONENT						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/16, 1966 to 1/2, 1985 , that (I) (we) lost saw the deceased alive on 1/2, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Donald R. McWilliams		DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/2/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. McWILLIAMS, M.D.		22e. ADDRESS 308 GAY STREET CAMBRIDGE, MD. 21613				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/85		23c. NAME OF CEMETERY OR CREMATORY E. NEW MARKET CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE E. NEW MARKET DOB MD.
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.		DATE RECEIVED JAN 8 1985		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Lelia M. Milligan			2a. DATE OF DEATH MONTH DAY YEAR January 10, 1985				2b. HOUR A. M. M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 24, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dorchester Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Hurlock		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2, Box 49				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 49 21643	
14. FATHER'S NAME FIRST MIDDLE LAST Clyde C. Harding					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Wroten				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-74-7342		17. INFORMANT ADDRESS Md. 21643 Norman E. Milligan, Rt. 2, Box 49, Hurlock,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 5 yrs ?									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-21 , 19 84 , to 1-10 , 19 85 , that (we) lost the deceased alive on 6-22 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. R. Trapnell MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 1-15-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. R. Trapnell, M.D.						22e. ADDRESS Bloomingdale Avenue, Federalsburg, Md. 21632			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Unity Washington Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock, Dorchester, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Frampton-Hawkins Funeral Home, 216 N. Main St. Federalsburg, Md.									

07-11-98

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Pauline - Paul				20. DATE OF DEATH MONTH DAY YEAR 1 21 1985 20. HOUR 8 10 PM			
3. SEX F		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 12 20 21		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.	
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD. 13b. COUNTY DORCHESTER 13c. CITY OR TOWN CHURCH CREEK				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE GENERAL DELIVERY 21622	
14. FATHER'S NAME FIRST MIDDLE LAST UNK.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE WINGATE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-10-0891		17. INFORMANT ADDRESS Olie O. Paul Church Creek Md. 21622			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE METASTATIC BRAIN TUMOR DUE TO, OR AS A CONSEQUENCE OF (b) SMALL CELL (INTERMEDIATE SIZE) CARCINOMA UPPER LOPR RT. LUNG DUE TO, OR AS A CONSEQUENCE OF (c) DETECTED 10/1/84							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEV. WKS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: MILD DEHYDRATION ON ADMISSION TO HOSP 1-21-85							
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-27, 19 84 to 1-21, 19 85 , that (I) (we) last saw the deceased alive on 1-21, 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DONALD R. MAULLIONS, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-21-85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 1/24/85		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.				24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME ADDRESS CAMBRIDGE MD.			
25a. DATE REC'D. BY REGISTRAR JAN 28 1985				25b. REGISTRAR'S SIGNATURE John K. ...			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 9 2 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VIVIAN L. PEARSON			2a. DATE OF DEATH MONTH DAY YEAR 1/11/85		2b. HOUR 6:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 6, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edwin O. Pearson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Louise Denny		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-76-6446		17. INFORMANT ADDRESS Hospital Records	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiogenic Shock - Acute M.I.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

STP cu of Breast neoplasmAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/8 19 85 to 1/11 19 85 , that (I) (we) last saw the deceased alive on 1/11 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE [Signature]		DEGREE [Signature]	22c. DATE SIGNED 1/11/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Cambridge, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-17-85	23c. NAME OF CEMETERY OR CREMATORY Silver Lake Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Dover, Delaware
24. FUNERAL DIRECTOR NAME Alphonse E. Hicks ADDRESS HICKS For FUNERALS, ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR JAN 18 1985	25b. REGISTRAR'S SIGNATURE [Signature]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 9 2 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Dorinda H. Pedersen</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1/31/85</i>			2b. HOUR <i>9:50 PM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 6, 1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i> MD.	
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Chief Officer</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Dorchester</i>		13c. CITY OR TOWN <i>Brookview</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>D. Pedersen</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hilma Jacobsen</i>		16. STREET ADDRESS / ZIP CODE <i>P.O. Box 51, Rhodesdale, Md. 21659</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>039-05-4216</i>		17. INFORMANT ADDRESS <i>Mrs. Helene Pedersen, Same as #13</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*MYOCARDIAL INFARCTION*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*Sudden*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) *Arteriosclerotic Heart Disease**Years.*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

Respiratory Failure, Liver Failure

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

*MD*ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

1/31/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

H. Edward Ayitte

22e. ADDRESS

*Cambridge Md.*23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) *Cremation*23b. DATE
*2-1-85*23c. NAME OF CEMETERY OR CREMATORY
*Salisbury Crematory*23d. LOCATION
CITY OR TOWN COUNTY STATE
SALISBURY, Wicomico, Md.

24. FUNERAL DIRECTOR

NAME
*CURRAN FUNERAL HOME*ADDRESS
CAMBRIDGE, MD

25a. DATE RECEIVED BY REGISTRAR

FEB 5 1985

25b. REGISTRAR'S SIGNATURE

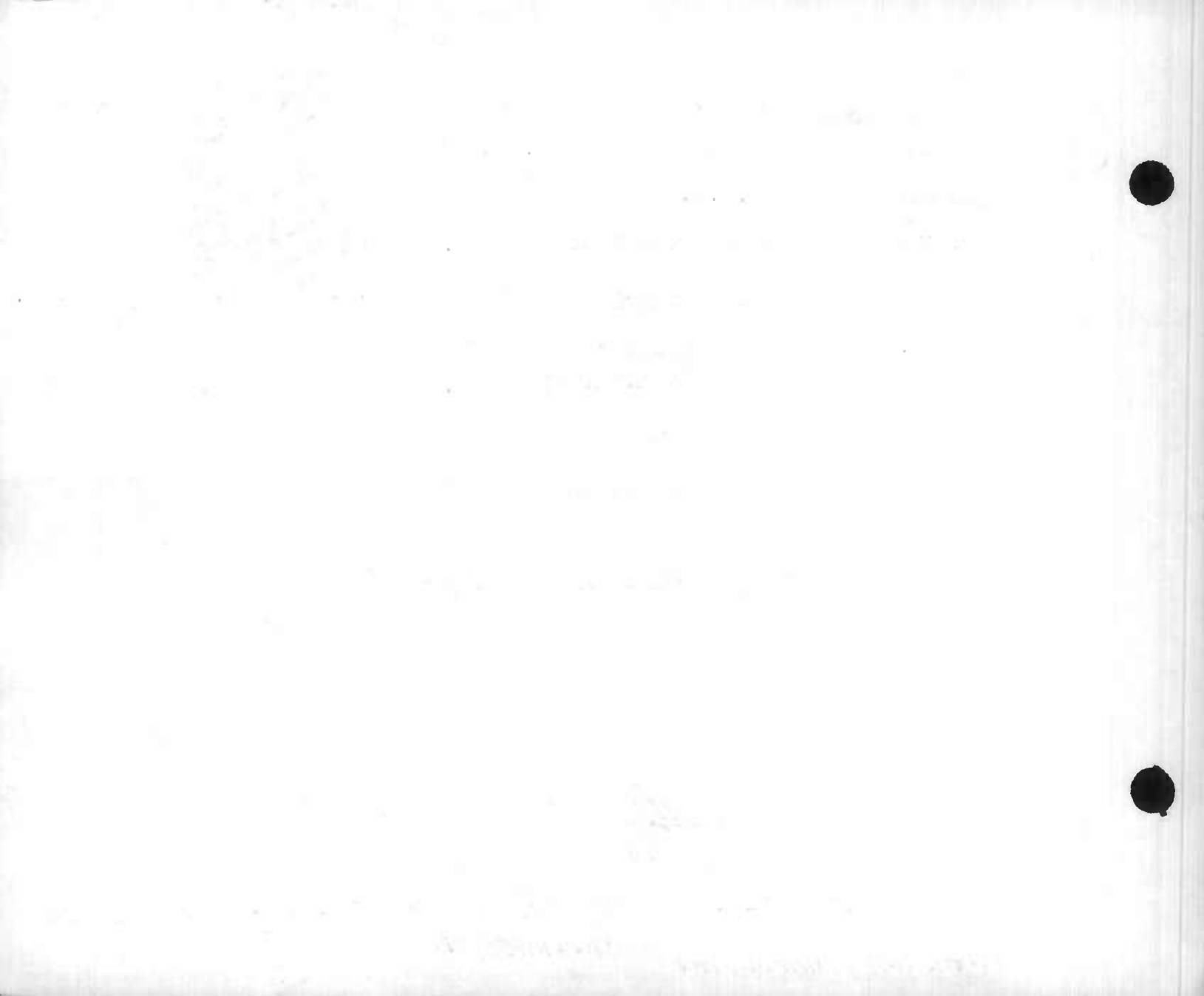
Julia Davidson-Randall

BP _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 9 2 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Edna</i>	MIDDLE <i>Slamm</i>	LAST <i>Peterson</i>	2a. DATE OF DEATH		MONTH <i>1</i>	DAY <i>27</i>	YEAR <i>85</i>	2b. HOUR <i>10.30 PM</i>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH <i>AUG.</i> DAY <i>28.</i> YEAR <i>1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS HOURS <i></i> MIN. <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.					
10. CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cambridge House Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waitress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Dorchester</i>		13c. CITY OR TOWN <i>Cambridge</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>21613 712 Church Street</i>			
14. FATHER'S NAME FIRST <i>Joseph</i> MIDDLE <i>Slamm</i> LAST <i></i>				15. MOTHER'S MAIDEN NAME FIRST <i>Elizabeth</i> MIDDLE <i></i> LAST <i>SEGAL</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>059-20-4673A</i>		17. INFORMANT <i>Daughter</i>				ADDRESS <i>Mrs. Edna McMullen, same as 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Pulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Possible acute MI</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVD - A. Fibrillation</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Organic B Syndrome</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> that (I) (we) lost saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>				DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>1/30/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Old Trinity Church Cem.</i>		23d. LOCATION CITY OR TOWN <i>Church Creek, Dor.</i>		COUNTY <i>Md 21622</i> STATE			
24. FUNERAL DIRECTOR NAME <i>Curran Funeral Home</i>		ADDRESS <i>308 High St. Cambridge, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 30 1985</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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20% COLLISION

CHATELAIN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 9 2 4

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRACE OLIVIA PORTER			2a. DATE OF DEATH MONTH DAY YEAR 1-31-85			2b. HOUR 10²⁰ AM	
3. SEX F	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 05-09-08	6. AGE (IN YEARS LAST BIRTHDAY) 76		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.				
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY DORCHESTER 13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 114 HIGH ST. APT 4 21613		
14. FATHER'S NAME FIRST MIDDLE LAST DAVID HARMON JONES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE OLIVIA WEEDON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 216-12-1323		17. INFORMANT (DAUGHTER) PATSY VICKERS 21622 PO BOX 603 CHURCH CREEK MD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

MASSIVE MYOCARDIAL INFARCTIONAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4+ HRS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) **ARTERIO-SCLEROTIC HEART DISEASE****3+ YRS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **GENERALIZED ARTERIO-SCLEROTIC DISEASE****3+ YRS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

HYPERTENSIVE CARDIOVASCULAR DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/18 1975 to 1/31 1985 , that (I) (we) last saw the deceased alive on 1/31 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.			
22b. SIGNATURE Donald R. McWilliams		DEGREE MD	22c. DATE SIGNED 1/31/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. MCWILLIAMS, M.D.		22e. ADDRESS 308 GAY ST. CAMBRIDGE, MD. 21613	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation	23b. DATE 2/1/85	23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR FEB 05 1985	25b. REGISTRAR'S SIGNATURE P. Davidson-Rendall

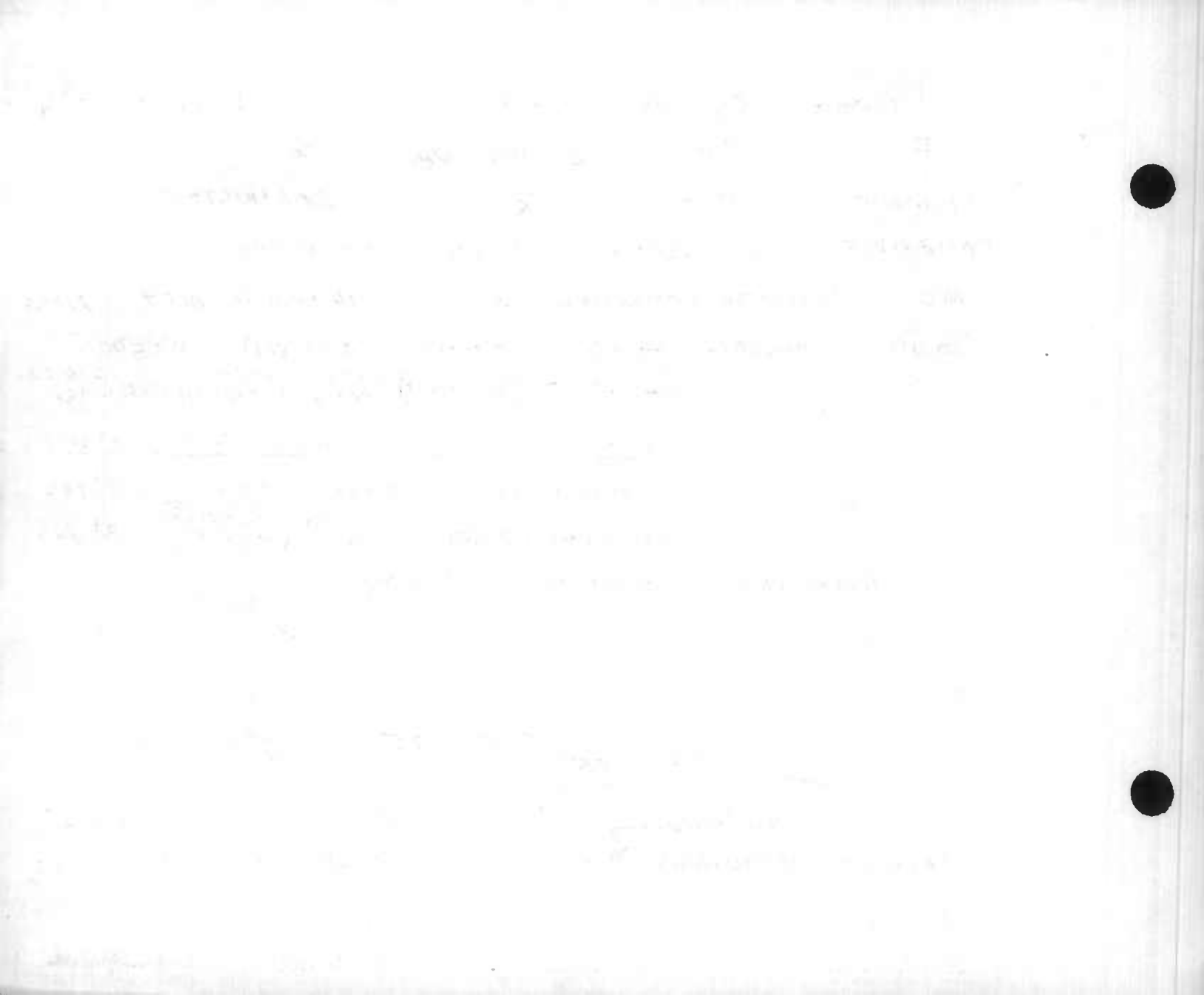
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 9 2 5

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Milton Campbell Robbins			2a. DATE OF DEATH MONTH DAY YEAR 1 12 85		2b. HOUR 9 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 28 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Robbins, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister	12b. KIND OF BUSINESS OR INDUSTRY Religion	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Dorchester	13c. CITY OR TOWN Robbins	
14. FATHER'S NAME FIRST MIDDLE LAST James Robbins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Hall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES no		16b. SOCIAL SECURITY NO. 220-10-6388		17. INFORMANT ADDRESS Mrs. Emma Robbins, Box #88, Crapo, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Hepatic Coma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

Liver Cirrhosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Hepatitis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

D. Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

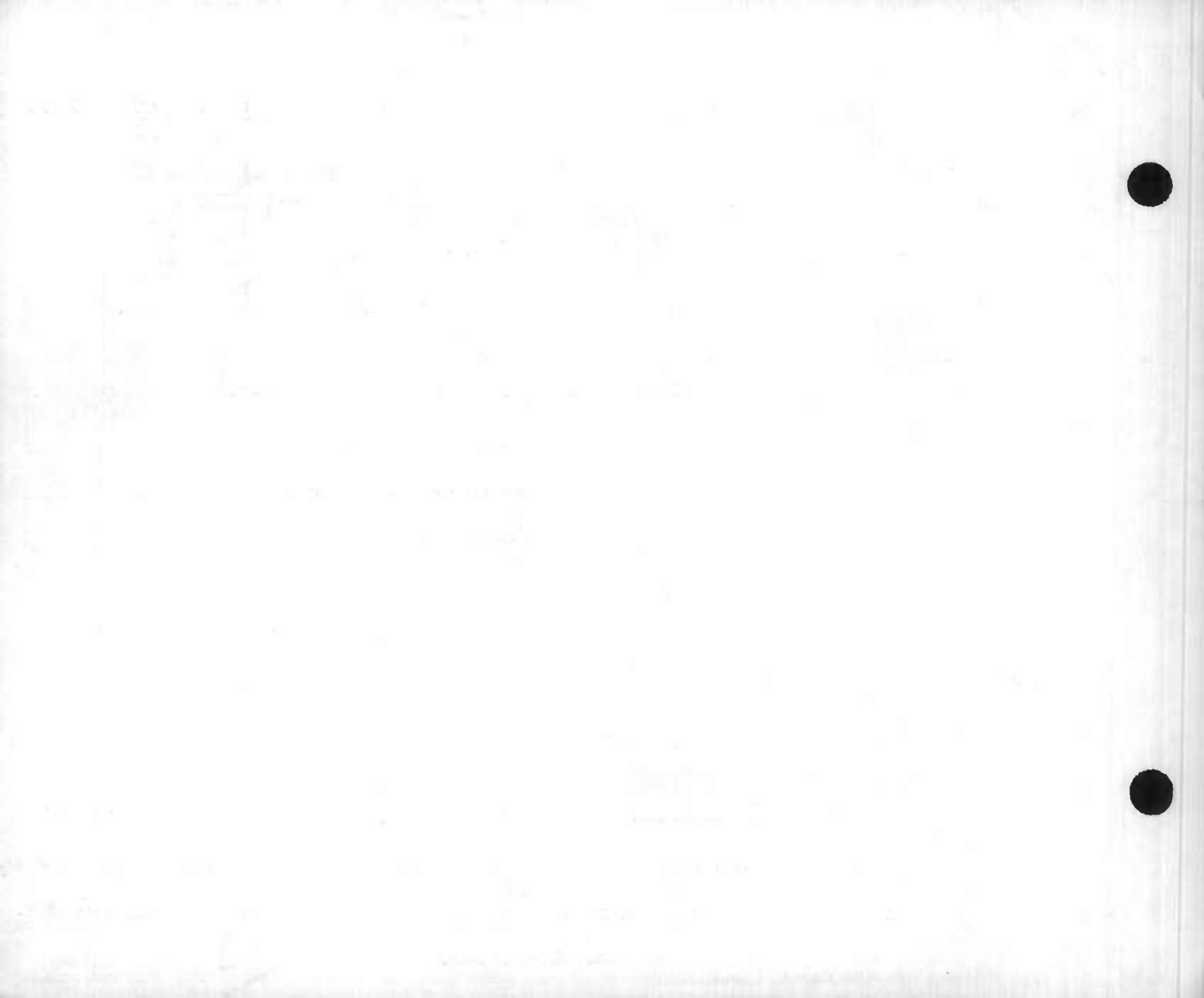
22b. SIGNATURE E. Tanman	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-12-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman		22e. ADDRESS 17 Franklin St. Cambridge, MD 21613	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-15-85	23c. NAME OF CEMETERY OR CREMATORY Dorchester Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, Md.
24. FUNERAL DIRECTOR NAME Curran Funeral Home		ADDRESS Cambridge, Md.	25a. DATE REC'D. BY REGISTRAR JAN 16 1985
		25b. REGISTRAR'S SIGNATURE John Davidson-Rendell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (b) or (c) showing injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 9 2 6

1. FOR
STATE
REGISTRAR

REG. NO.

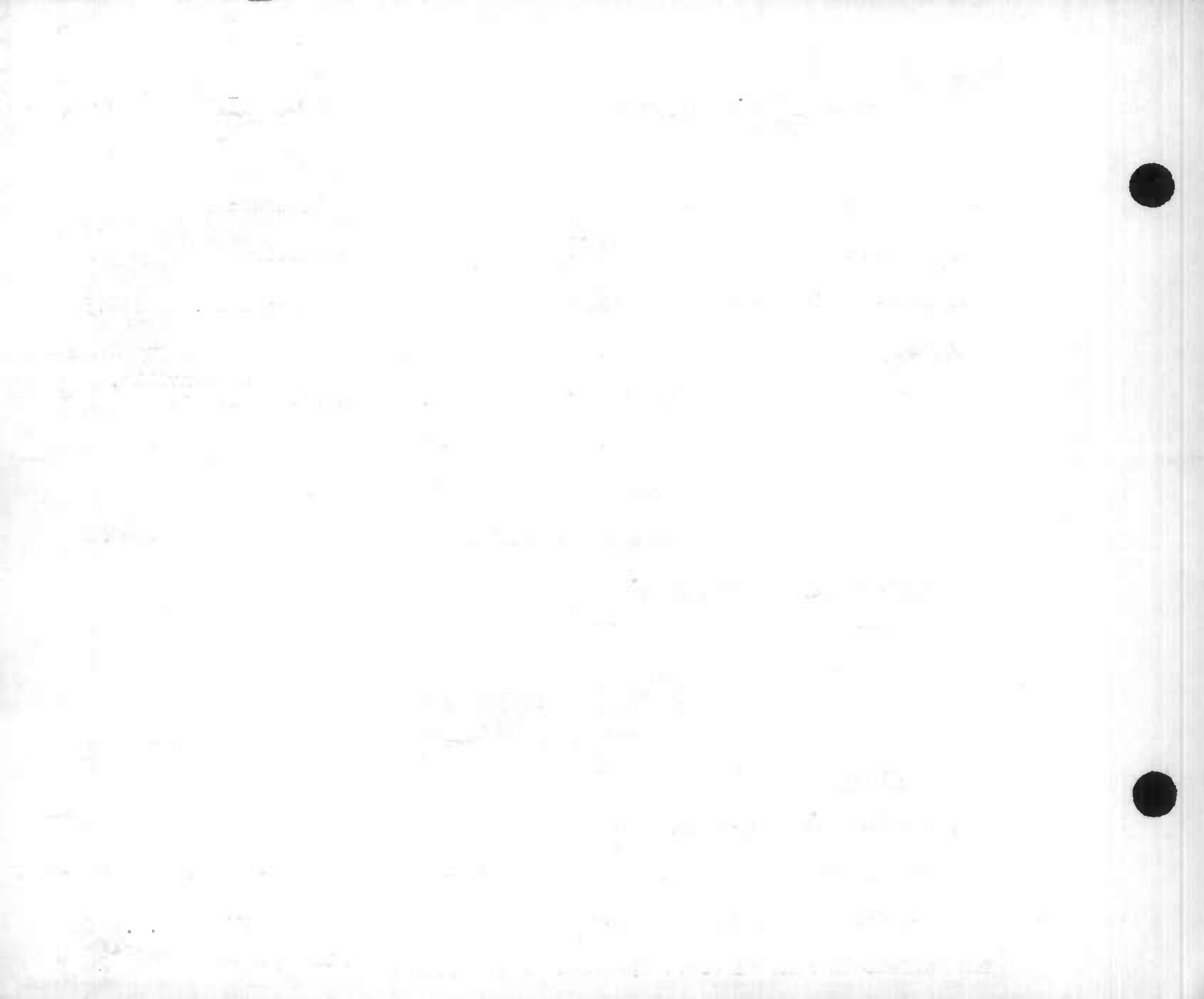
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie Cecelia Thomas			2a. DATE OF DEATH MONTH DAY YEAR JAN 6 1985		2b. HOUR 12:45 AM
3. SEX F	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR 11 20 12		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Thompson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-34-3351		17. INFORMANT ADDRESS Palmer D. Swann, Rt. 1 Box 189C Grasonville, MD 21638	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) HEPATIC FAILURE					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —	
22a. I certify that (I) (this hospital) attended the deceased from 12/05 19 84 to 1/6 19 85 , that (I) (we) lost saw the deceased alive on 1/5 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death.					
22b. SIGNATURE Michael A. Moskewicz MD		DEGREE MD		22c. DATE SIGNED 1/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ		22e. ADDRESS 503 BYRN ST. CAMBRIDGE MD 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01/09/95		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetary	
23d. LOCATION CITY OR TOWN COUNTY STATE Stevensville Q.A. MD		24. FUNERAL DIRECTOR NAME ADDRESS Tom Helfenbein Funeral Home, Chester, MD 21613			
25a. DATE REC'D. BY REGISTRAR JAN 1 6 1985		25b. REGISTRAR'S SIGNATURE J. L. Davidson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 85 01927			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1/17/85			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD (Tilghmon) TILGHMAN				2b. HOUR 5:00 M			
3 SEX M		4 RACE N		5. DATE OF BIRTH MONTH DAY YEAR 5 2 06		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philadelphia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Shore Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Gardener		12b. KIND OF BUSINESS OR INDUSTRY & Chauffeur	
13a. STATE Md				13b. COUNTY Caroline		13c. CITY OR TOWN Denton	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown George Tilghmon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Carrie Tilghmon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WWII 216-18-8218		17. INFORMANT ADDRESS Maryland 21629	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH None			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cachexia				8 weeks			
(c) Carcinoma of prostate w metastases				More than 8 months			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 15 JUNE 19 84 to JAN 17 19 85, that (we) last saw the deceased alive on 17 JAN 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul A. Stagg MD				DEGREE		22c. DATE SIGNED 17 Jan 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 21, 1985		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Beulah, Dorchester, Md.	
24. FUNERAL DIRECTOR NAME Frankton Hanlon				25. DATE REC'D. BY REGISTRAR JAN 24 1985		25b. REGISTRAR'S SIGNATURE John Davidson	

NOTED



2

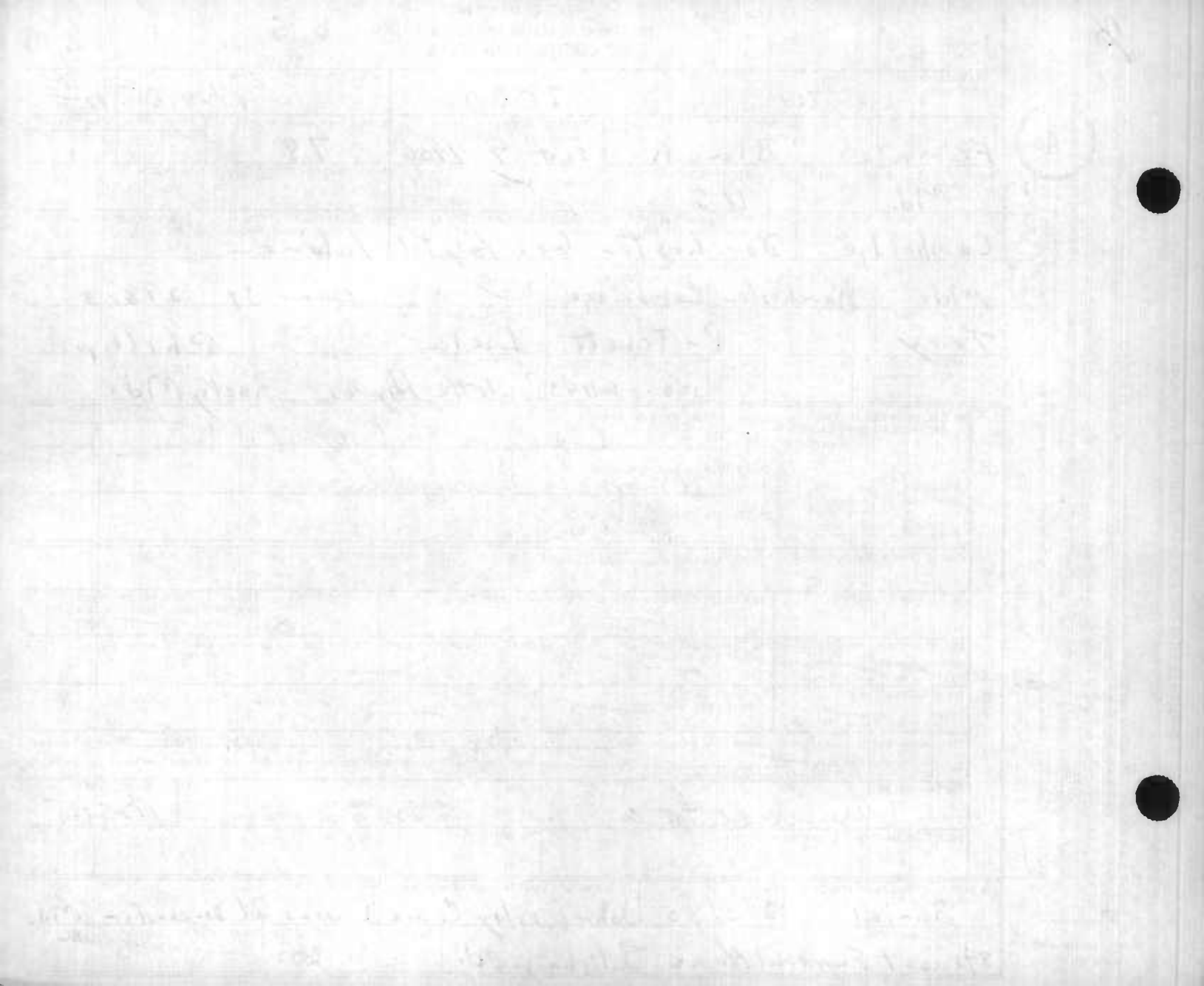
Handwritten text at the bottom, possibly a signature or date, including "1944" and "1945".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 5 0 1 9 2 8																			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 1/28/85							2b. HOUR 12 P M																	
1. DECEASED NAME (TYPE OR PRINT) ESTELA TODD					3. SEX Female							4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sept 7 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U S		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD					
10. CITY OR TOWN OF DEATH Cambridge					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer					12b. KIND OF BUSINESS OR INDUSTRY														
13a. STATE Md.					13b. COUNTY Dorchester					13c. CITY OR TOWN Cambridge					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE Burr St 21613									
14. FATHER'S NAME (TYPE OR PRINT) Tony					15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Lula Phillip					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. 220-03-1193					17. INFORMANT Paulette Hyres					ADDRESS Rocky, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure & Uremia. DUE TO, OR AS A CONSEQUENCE OF (b) Uremic Pericarditis DUE TO, OR AS A CONSEQUENCE OF (c) Anemia.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (this hospital) attended the deceased from 1/28, 1985, to 1/28, 1985, that (I) (we) last saw the deceased alive on 1/28, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE [Signature]										DEGREE					22c. DATE SIGNED 1/28/85														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 2/3/85					23c. NAME OF CEMETERY OR CREMATORY John Wesley Come Home - 5 Rd. Dorchester - Md.					23d. LOCATION CITY OR TOWN COUNTY STATE														
24. FUNERAL DIRECTOR NAME STEWART FUNERAL HOME										ADDRESS Salisbury, Md.					25a. DATE REC'D. BY REGISTRAR FEB 1 1985					25b. REGISTRAR'S SIGNATURE [Signature]									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 5 0 1 9 2 9			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) <i>last</i> <i>middle P. 1st</i> Tyndall, Ermyl				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 01 16 85 5 A. M.			
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 6 9 99	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE	7b. CITIZEN OF WHAT COUNTRY? USA ?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.				
10. CITY OR TOWN OF DEATH Cambridge, MO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Shore Hospital Center		12a. USUAL OCCUPATION (IF NOT MOST OF WORKING LIFE) Farmer Retired		12b. KIND OF BUSINESS OR INDUSTRY own Farm		
13a. USUAL RESIDENCE (IF HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MO.	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Salisbury Nursing Home 21801				
14. FATHER'S NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM ? E. TYNDALL	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA ? HITCHENS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) (IF YES, GIVE WAR OR DATES) NO UNKNOWN				
16b. SOCIAL SECURITY NO. 221-40-4769		17. INFORMANT ADDRESS Mrs. Debbie Cooper 210 Lincoln Ave. Salisbury, Md 21801					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Respiratory failure</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A. Possible pneumonia</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus, very long time</p>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE MEHDI GHAZINOR-NAINI		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 01-16-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEHDI GHAZINOR-NAINI		22e. ADDRESS ESH C					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Asbury Church Cemetery near Laurel Delaware		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR (NAME) James L. Disharoon		ADDRESS P.O. Box 670 Pile 199		25a. DATE REC'D. BY REGISTRAR JAN 21 1985			
25b. REGISTRAR'S SIGNATURE John Davidson							

A

MEDICAL CERTIFICATION

A



REGISTERED

MAILED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

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RECEIVED
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner may be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 5 0 1 9 3 0			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT) Peter JAN VAN Huizen				1/7/85			
3. SEX M				4. RACE CAUCASIAN			
5. DATE OF BIRTH 2 17 03				6. AGE 81 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Netherlands				7b. CITIZEN OF WHAT COUNTRY? U.S.A.			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager, U.S.				12b. KIND OF BUSINESS OR INDUSTRY Wildlife Ser.			
13a. STATE MD				13b. CITY OR TOWN Dorchester			
13c. INSIDE CITY LIMITS? NO				13d. STREET ADDRESS / ZIP CODE 24 Belle Vue Ave 21613			
14. FATHER'S NAME Pieter Jan Van Huizen				15. MOTHER'S MAIDEN NAME Helena Kleyn-Schoorel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 431-66-1764			
17. INFORMANT Dr. Pieter J. Van Huizen				ADDRESS Item #13			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.			
(b) _____ DUE TO, OR AS A CONSEQUENCE OF							
(c) _____ DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) PARKINSONISM							
19a. DATE OF OPERATION N/A				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. LOCATION (CITY OR TOWN COUNTY STATE)			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION (CITY OR TOWN COUNTY STATE)			
22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19 JAN 17 , 19 85 , that (I) (we) last saw the deceased alive on 12/84 , 19 85 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. Neal Reynolds DEGREE MD				22c. DATE SIGNED 1/7/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Neal Reynolds				22e. ADDRESS 408 Bxyn St. Cambridge MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE 1/9/85			
23c. NAME OF CEMETERY OR CREMATORY TRINITY CHURCHYARD				23d. LOCATION (CITY OR TOWN COUNTY STATE) CHURCH CREEK DOR. STATE MD.			
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR JAN 16 1985			
ADDRESS CAMBRIDGE MD.				25b. REGISTRAR'S SIGNATURE John Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 1 9 3 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Theodore E. Walter			2a. DATE OF DEATH MONTH DAY YEAR 01-20-85			2b. HOUR 1:49 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 04 09 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
12. CITY OR TOWN OF DEATH Cambridge		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Watchman		15. KIND OF BUSINESS OR INDUSTRY Mfg.	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Md.			16b. CITY OR TOWN Caroline		16c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16d. STREET ADDRESS / ZIP CODE Houston Branch Rd. 21632		
17. FATHER'S NAME FIRST MIDDLE LAST Christopher Travers Walter			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Emily Smith			19. ADDRESS Rt. 1 Box 396 Federalsburg Md.			
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		21. SOCIAL SECURITY NO. 217-14-8844		22. INFORMANT Della E. Walter		23. ADDRESS Rt. 1 Box 396 Federalsburg Md.			
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory failure. DUE TO, OR AS A CONSEQUENCE OF (b) Chronic pulmonary disease. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
28a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION STREET CITY OR TOWN COUNTY STATE					
29. I certify that (I) (this hospital) attended the deceased from 1/15/85 to 1/20/85 , that (I) (we) lost saw the deceased alive on 1/20/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
30a. SIGNATURE [Signature]		30b. DEGREE MD		30c. MEDICAL PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		30d. DATE SIGNED 1/20/85			
31a. PHYSICIAN'S NAME (TYPE OR PRINT) Adelle		31b. ADDRESS 4cc Maryland Ave		31c. ZIP CODE 21613					
32a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		32b. DATE 1/23/84		32c. NAME OF CEMETERY OR CREMATORY Dor. Memorial Pk.		32d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.			
33. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME				33b. ADDRESS CAMBRIDGE MD.		34. DATE REC'D. BY REGISTRAR JAN 24 1985		35. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 2/80

FOR 1- STATE REGISTRAR										FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE										0 1 9 3 2									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT) Maagie Bromwell Waters										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1 1 1985										2b. HOUR 11 AM									
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 12 5 92		6. AGE (IN YEARS) LAST BIRTHDAY 92 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 1 1985		7d. HOUR 11 AM															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.																	
10. CITY OR TOWN OF DEATH Cambridge				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER				12b. KIND OF BUSINESS OR INDUSTRY RET.																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 21613 629 Schoolhouse Lane									
13a. STATE MD		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Jolley				17. INFORMANT ADDRESS ELLA MAE DOWNS 601 HIGH ST. CAMB, MD.																			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bromwell				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-32-1449				17. INFORMANT ADDRESS ELLA MAE DOWNS 601 HIGH ST. CAMB, MD.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										22b. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE John Mace Jr.				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER JOHN MACE JR.				DATE SIGNED 1/1/85																	
EXAMINER'S NAME (TYPE OR PRINT) JOHN MACE JR.				ADDRESS CAMBRIDGE MD																									
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 4-05-85				23c. NAME OF CEMETERY OR CREMATORY WAUGH				23d. LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE DOR. MD.																	
24. FUNERAL DIRECTOR NAME J. K. Clark				ADDRESS 31 CLAIR F. HOME CAMBRIDGE, MD.				25a. DATE REC'D. BY REGISTRAR JAN 3 1985				25b. REGISTRAR'S SIGNATURE R. P. Clark																	

MEDICAL CERTIFICATION

1952

1952



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8501933			
1. DECEASED NAME (TYPE OR PRINT) JAMES WHEATLEY										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 1 20 19 85		2b. HOUR 10a <input type="checkbox"/> 10a <input type="checkbox"/>	
3 SEX M		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 9 7 12		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 72 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 20 19 85		2d. HOUR 10a <input type="checkbox"/> 10a <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MD.	
10. CITY OR TOWN OF DEATH Cambridge, Md.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Genl Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Dorchester 13c. CITY OR TOWN Cambridge										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 502 Dobson Street 21613	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO. 213-14-8523					17. INFORMANT Ellen Stanley ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: coronary occlusion IMMEDIATE CAUSE (a) coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John Mace						TITLE (SPECIFY) M.D. Deputy			DATE SIGNED 1-20-85				
EXAMINER'S NAME (TYPE OR PRINT) John Mace, M.D.						ADDRESS 604 Church St. Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/24/85		23c. NAME OF CEMETERY OR CREMATORY Bethel Ceme.			23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dorchester Md.				
24. FUNERAL DIRECTOR NAME Stewart Funeral Home ADDRESS Salisbury, Md.						25a. DATE REC'D BY REGISTRAR JAN 21 1985 25b. REGISTRAR'S SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

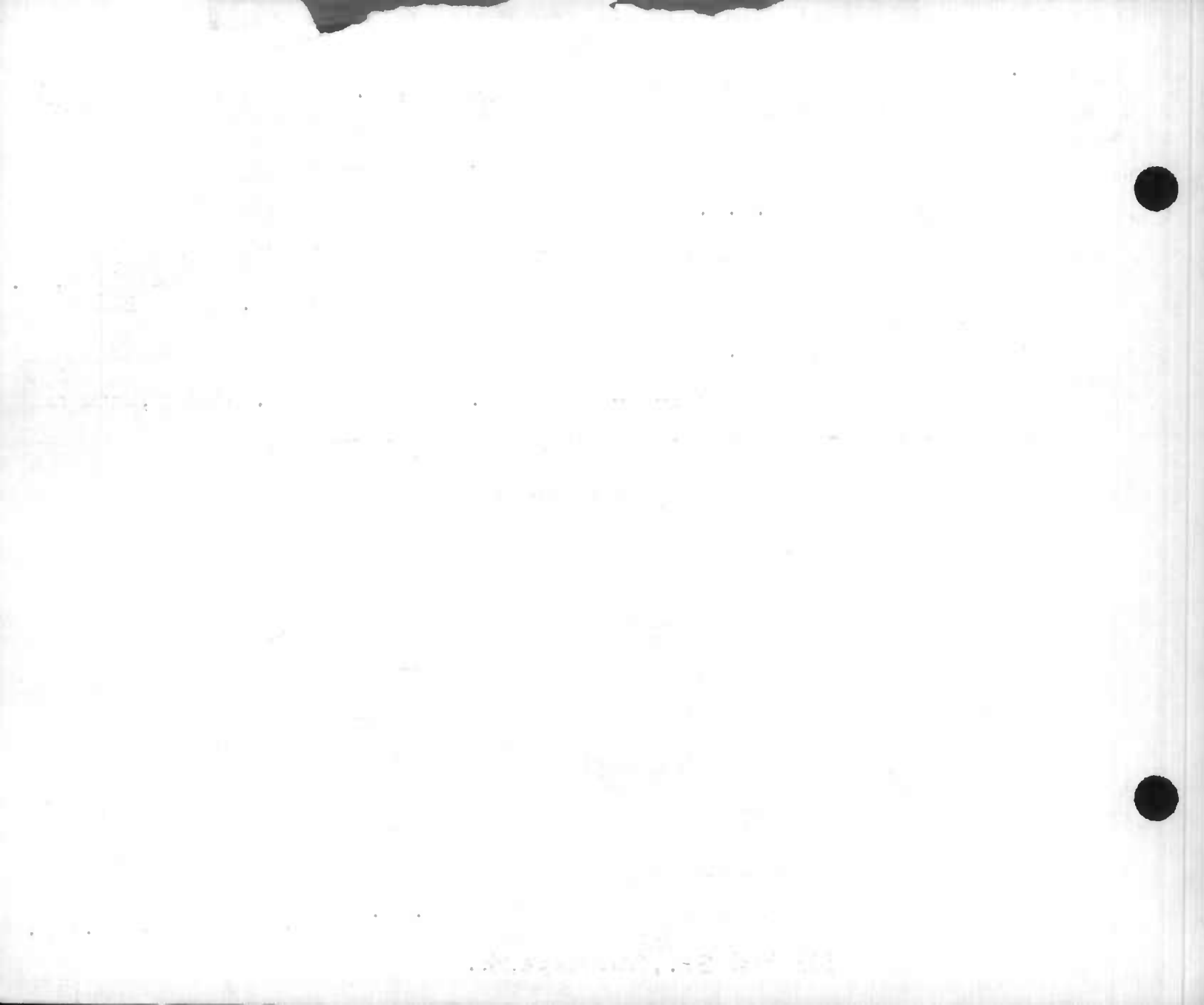
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called in to examine the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8501934		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST ROMMIE MIDDLE THOMAS LAST WILLEY, SR.		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		2c. MIN.	
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STREET ADDRESS / ZIP CODE		13b. KIND OF BUSINESS OR INDUSTRY		13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (wife) ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 1. DEATH WAS CAUSED BY:		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> WORK	
IMMEDIATE CAUSE (a) Metastatic Ca of Colon		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 1/19/85 to 1/28/85, that (I) (we) last saw the deceased alive on 1/28/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE	
DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION CITY OR TOWN COUNTY STATE		22e. DATE SIGNED		22f. REGISTRAR'S SIGNATURE	
DUE TO, OR AS A CONSEQUENCE OF (c)		22g. PHYSICIAN'S NAME (TYPE OR PRINT)		22h. ADDRESS		22i. DATE REC'D. BY REGISTRAR		22j. REGISTRAR'S SIGNATURE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
		burial		1/31/85		Dorchester Mem. Pk.		Airey, Cambridge, Dor., Md.	
		24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		24d. DATE REC'D. BY REGISTRAR	
		Curran Funeral Home		308 High St., Cambridge, Md.		JAN 30 1985		John Davidson-Randall	

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 01935

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bess Rose Wilson			2a. DATE OF DEATH MONTH DAY YEAR Jan. 9, 1985		2b. HOUR 8:45 P.
3. SEX female	4. RACE cau.	5. DATE OF BIRTH MONTH DAY YEAR 08 20 99		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD	
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CAMBRIDGE HOUSE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 46 Algonquin Rd. 21613
14. FATHER'S NAME FIRST MIDDLE LAST Allison Rose			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST America Haddix		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 236-36-7909		17. INFORMANT daughter Mrs. Dorothy Vincent, same as 13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 39 days 24 hrs.
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/17/84, 19, to 1/9/85, 19, that (I) (we) last saw the deceased alive on 1/9/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lawrence Mangano, MD		DEGREE MD		22c. DATE SIGNED 1/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Mangano, MD		22e. ADDRESS 600 RACE ST. Cambridge, MD 21613			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 1/13/85	23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Peck's Mill, W. Va.
24. FUNERAL DIRECTOR NAME Curran Funeral Home		25a. DATE REC'D. BY REGISTRAR JAN 14 1985	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 77 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Base Wilson
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CHILFAW

20% COTTON

